Department Of Medical Assistance Services (DMAS)
Intensive Rehabilitation 60-Day Recertification

(Instructions for the completion of this form are located on the reverse side)

60-Day Recertification Statement

I. Recertification Statement:

In accordance with 42 CFR 456.60, I certify that _____(patient's full name) continues to be appropriate for inpatient rehabilitation services and shall meet the Medicaid intensive rehabilitation criteria for the next 60 days as set forth in 12 VAC 30-60-120. This recertification is based on my review of the individual's current medical record documentation.

II. Criteria Determination:

(In order to meet intensive rehabilitation services criteria the recipient must require all the items listed below)

The rehabilitation program cannot be safely and adequately carried out in a less intensive setting; and

The recipient is able to actively participate in the intensive rehabilitation treatment plan developed by the interdisciplinary team; and

The interdisciplinary coordinated team approach is required; and

The recipient requires rehabilitation nursing services for patient/family education in addition to skilled nursing care; and

The recipient requires at least two of the four therapies:
(Check the appropriate boxes)

Physical Therapy services on a daily basis

Occupational Therapy services on a daily basis

Cognitive Therapy services on a daily basis

Speech-Language Pathology services on a daily basis

III. Physician Signature Required:

_____

Physician Signature (month/day/year)

Instructions for Completion of the DMAS
Intensive Rehabilitation 60-Day Recertification Form

I. In accordance with 42 CFR 456.60, the physician must recertify for each recipient that inpatient services in a hospital are needed. The recertification must be made at least every 60 days after certification. The recipient's full name shall be entered in this space provided.

II. In order to meet intensive rehabilitation services criteria the recipient must require all the items listed. In the section that identifies the four (4) rehabilitation therapies check the appropriate boxes.

II. The physician shall fully sign and date (month/day/year) his/her signature. Only the physician can date his/her signature.

***This form serves as the instructions for completion of the physician 60-day recertification. The physician must complete this form to meet recertification documentation requirements for the intensive rehabilitation program.**